

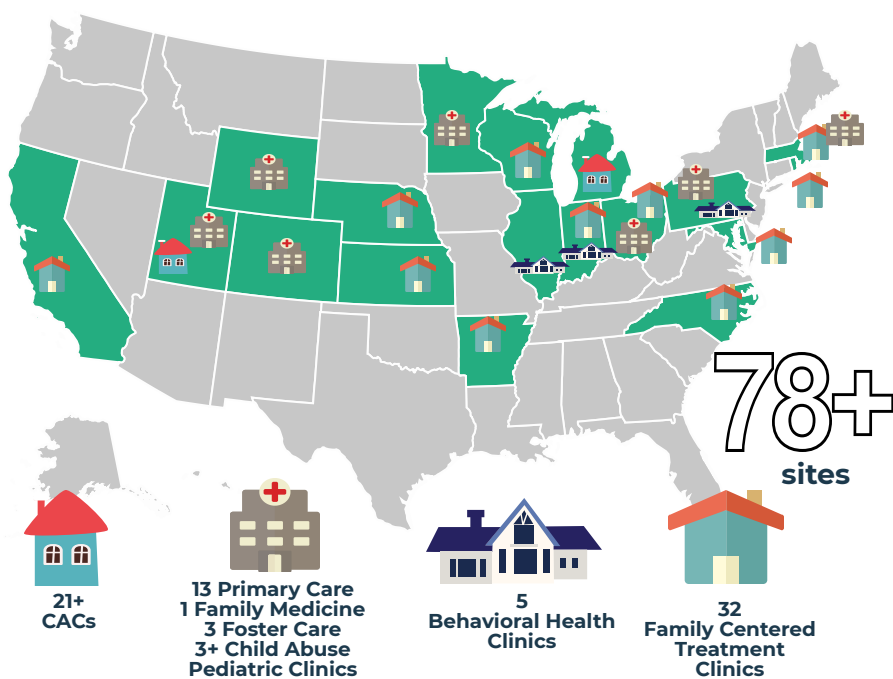
Pediatric Integrated Post-trauma Services (PIPS) is a Treatment and Service Adaptation Center (Category II) of the National Child Traumatic Stress Network (NCTSN).



PIPS developed the Care Process Model for Pediatric Traumatic Stress (CPM-PTS) to facilitate traumatic stress screening and response for children seen in healthcare and other pediatric settings. The PIPS Update is a quarterly report and newsletter.

CPM-PTS Tracking

Map & Dashboard of Active CPM-PTS Sites



CPM-PTS Training Contacts



Quarter: 125

Total: 2,155+

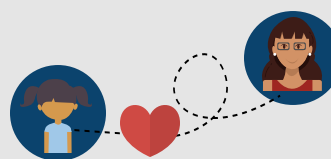
Screening via the CPM-PTS

Quarter: 6,262+

Total: 33,598+



EBT Referral via the CPM-PTS



Quarter: 966+

Total: 3,702+

We Received Two New Funding Awards!



We received a funding award from the Cambia Health Foundation in collaboration with the National Children's Alliance (NCA) and Utah Children's Justice Center (CJC) Program to continue training and support of the CPM-PTS in rural CJsCs in Utah.



We received a funding award from the Intermountain Foundation in collaboration with Primary Children's Hospital Center for Safe and Healthy Families to continue training and support of the CPM-PTS in Intermountain and community primary care clinics.



Our New Funding Awards Will Build on Work We Have Already Been Doing in Utah

28800+
Children Screened



4,950+
CJs



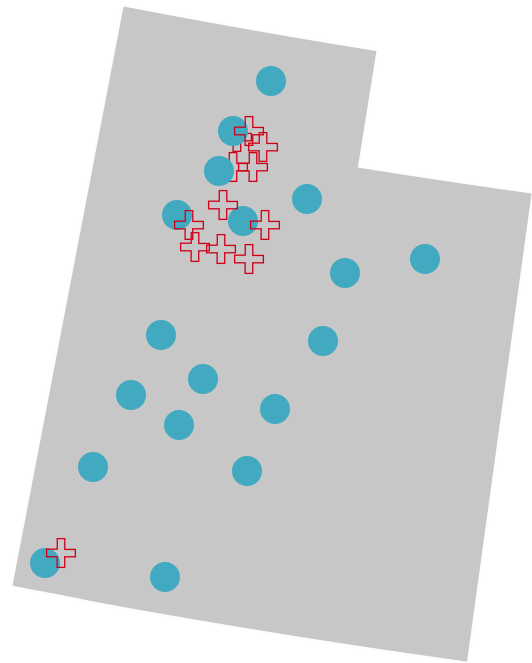
23,800+
Primary
Care Clinics

31+
Active Sites

● 19 CJs

✚ 11 Primary
Care Clinics

✚ 1 Child
Abuse Clinic
& Children's
Hospital



Our Pilot Combining the CPM-PTS with SAFETY-A for Suicide Prevention in the ED was Published

EVIDENCE-BASED PRACTICE IN CHILD AND ADOLESCENT MENTAL HEALTH
2021, VOL. 6, NO. 3, 343-353
<https://doi.org/10.1080/21744525.2021.1961643>



Check for updates

Implementation of a Trauma-Informed Suicide Prevention Intervention for Youth Presenting to the Emergency Department in Crisis

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ABSTRACT

Given the increasing number of children presenting to the emergency department (ED) in psychiatric crisis, our tertiary children's hospital ED adopted SAFETY-Acute/Family Intervention for Suicide Prevention (SAFETY-A), an evidence-based practice for suicide prevention. Because of the relationship between trauma and suicide among youth, this study piloted the feasibility of combining SAFETY-A and a standardized approach to the detection and response to trauma in youth, the Care Process Model for Pediatric Traumatic Stress (CPM-PTS) within a busy ED setting. Over a three-month period, 30 youth with low to moderate risk for suicide received SAFETY-A+CPM in the ED. 62% of respondents reported trauma exposure, with the majority endorsing moderate or severe traumatic stress symptoms. Twenty-nine of the 30 youth were able to be safely discharged home with follow-up care. Fifteen youth were provided referrals/linkages with new providers, 5 of which were to trauma-focused assessment and treatment as indicated by the CPM-PTS. Overall, crisis workers found that offering SAFETY-A+CPM was "more rewarding" than traditional crisis evaluations and that using trauma-specific data identified with the CPM-PTS was quite helpful. Post-intervention surveys with parents indicated a favorable experience, comfort with maintaining safety, and overall satisfaction with the ED intervention. Clinical and system barriers identified over the course of the pilot are critical to address for sustained delivery. Overall, SAFETY-A was able to be delivered to fidelity and blended with the CPM-PTS.

Introduction

Suicide is the second leading cause of death for young persons, 10–24 years old, in the United States (Cha et al., 2018; Curtin & Heron, 2019) and the leading cause of death for young persons in many US states (Curtin, 2020). With age-adjusted rates of death caused by suicide increasing 24% nationally from 1999 through 2014 (Curtin et al., 2016), suicide prevention has become a top public health priority, including the development and promotion of youth suicide risk screening tools (Horowitz et al., 2009) and response protocols for high-risk populations.

Not all youth share the same level of risk, even within the same setting, and it is important for clinicians to be able to quickly differentiate risk and modify intervention strategies to target specific risk characteristics. Some youth are at greater risk for suicide based on their demographic, familial, and clinical characteristics, access to lethal means, and life experiences, including potentially traumatic

events (Brezo et al., 2008; Carballo et al., 2020; Cash & Bridge, 2009; Fergusson et al., 2008; Keeshin et al., 2018; Knopov et al., 2019). History of attempted suicide is also a strong predictor of subsequent suicide attempt and death by suicide (Harris & Barraclough, 1997), and children with prior suicide attempts are an increasing percentage of those presenting to emergency departments (EDs) for crisis services (Bardach et al., 2014; Burstein et al., 2019; Kallb et al., 2019; Plemmons et al., 2018).

The response to a growing and more severely impacted population of suicidal youth presenting to emergency departments for crisis evaluations has been limited. Nationally, between 2011 and 2015, suicide-related visits among adolescents increased by 2.5 times. ED visits tended to be long (≥ 3 hours), and only a few youth (16%) accessed a mental health provider during their visit (Kallb et al., 2019). This means that youth with suicidality are increasingly presenting to the ED, and although the ED is a critical opportunity for suicide risk

Because trauma and subsequent traumatic stress are potent risk factors for suicidality, we thought that the Care Process Model for Pediatric Traumatic Stress (CPM-PTS) may help identify and respond to trauma for youth presenting to the Emergency Department (ED) for crisis evaluation.

The CPM-PTS was combined with SAFETY-Acute/Family Intervention for Suicide Prevention (SAFETY-A), a trauma-informed intervention for suicide prevention, at Primary Children's Hospital ED and piloted for feasibility. Over a 3-month period, 30 youth with low to moderate risk for suicide received SAFETY-A+CPM in the ED. 62% of respondents reported trauma exposure, with the majority endorsing moderate or severe traumatic stress symptoms. Twenty-nine of the 30 youth were able to be safely discharged home with follow-up care. Fifteen youth were provided referrals/linkages with new providers, 5 of which were to trauma-focused assessment and treatment as indicated by the CPM-PTS. Overall, crisis workers found that offering SAFETY-A + CPM was "more rewarding" than traditional crisis evaluations and that using trauma-specific data identified with the CPM-PTS was quite helpful.

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Click [here](#) to go to the full article, or message lindsay.shepard@hsc.utah.edu for article access.

The CPM-PTS is Referenced in an AAP Clinical Report on Trauma-Informed Care

A recent clinical report of the American Academy of Pediatrics (AAP) practically addresses trauma-informed care for pediatric clinicians and references the Care Process Model for Pediatric Traumatic Stress (CPM-PTS) as a validated means of screening for pediatric traumatic stress.

Click [here](#) to go to the full article (the CPM-PTS is referenced on page 10).

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care
American Academy of Pediatrics
DEPARTMENT OF THE HEALTH OF ALL CHILDREN™

Trauma-Informed Care

Wheaton, Corwin, MS, MAPP; Horta-Schlag, MD, PhD, MAPP; Fink, J, MD, MPH, MEd; Jones-Duffy, MD, MPH, MEd; THE CLINICAL GUIDANCE GROUP; SOURCE: IN COLLABORATION WITH PEDIATRIC LEADERS ON CHILD ABUSE AND NEGLECT COMMITTEE ON PHYSICIAN ASSISTANTS OF CHILD AND ADOLESCENT

Abstract
Most children will experience some type of trauma during childhood, and many children suffer from significant adverse effects. Research in genetics, neuroscience, and epidemiology all provide evidence that these experiences have effects at the molecular, cellular, and organ levels with consequences on physical, emotional, developmental, and behavioral health across the life span. Trauma-informed care translates that science to inform and improve pediatric care and outcomes. To practically address trauma and promote resilience, pediatric clinicians need tools to assess childhood trauma and adversity experiences as well as practical guidance, resources, and interventions. In this clinical report, we summarize current, practical advice for rendering trauma-informed care across varied medical settings.

Introduction
Experiences in childhood, both positive and negative, have a significant effect on subsequent health, mental health, and developmental trajectories. For many children and adolescents, traumatic experiences are all too common. Almost one half of American children, or 34 million younger than 18 years, have had at least 1 potentially traumatic early childhood experience.¹⁷ Such traumas may include those originating outside the home, such as community violence, natural disasters, unintentional injury, terrorism, incest, and/or refugee trauma (including detention, discrimination,^{18,19} racism), and/or those involving the caregiving relationship, such as intimate partner violence, parental substance use, parental mental illness, caregiver death, separation from a caregiver, neglect, or abuse, originally defined as adverse childhood experiences (ACEs).²⁰ For many children, medical events, such as injury, medical procedures, and/or intensive medical treatments, can be traumatic. Given the robust science explaining the physiologic consequences of accumulated trauma experience on the brain and body,^{17,18} there have been calls for pediatric clinicians to address childhood trauma and child traumatic stress.^{17,18} However,

are doing the best they can.^{17,20,21} Adverse events that include in these conversations and have a role in identifying strengths and challenges. Pediatricians who have cared for a family over time may already have considerable insight into the family's dynamics and be able to engage the caregivers in an empathic yet open conversation. Furthermore, compassionate surveillance can be combined with use of screens or questionnaires to elicit more information.

Screening
Validated screens used at preventive health care visits can provide valuable information about child development, mental health, and behavior.²² They can be reassuring when normal or alert the pediatric provider to symptoms or risks when borderline or abnormal. Commonly used tools, such as the Ages and Stages Questionnaire,²³ the Pediatric Symptom Checklist,²⁴ the Strengths and Difficulties Questionnaire,²⁵ and the Patient Health Questionnaire-9²⁶ may elicit symptoms that are the possible result of trauma (developmental delay, social-emotional problems, anxiety, etc.). Periodic depression screening may not only identify symptoms of ill health but provide opportunities to explore material stressors and symptoms.²⁷ These exposed to known traumas can be evaluated by using standardized post-traumatic stress disorder (PTSD) screening tools such as the PTSD Checklist for DSM-5²⁸ and those exposed to medical traumas can be evaluated by using a tool such as the Psychological Trauma Inventory.²⁹

Pediatric Traumatic Stress Screening Tool in the International Care Process Model
The International Care Process Model has been recently discussed in screen for pediatric traumatic stress in the primary care setting, either as a universal screen or with targeted screening when

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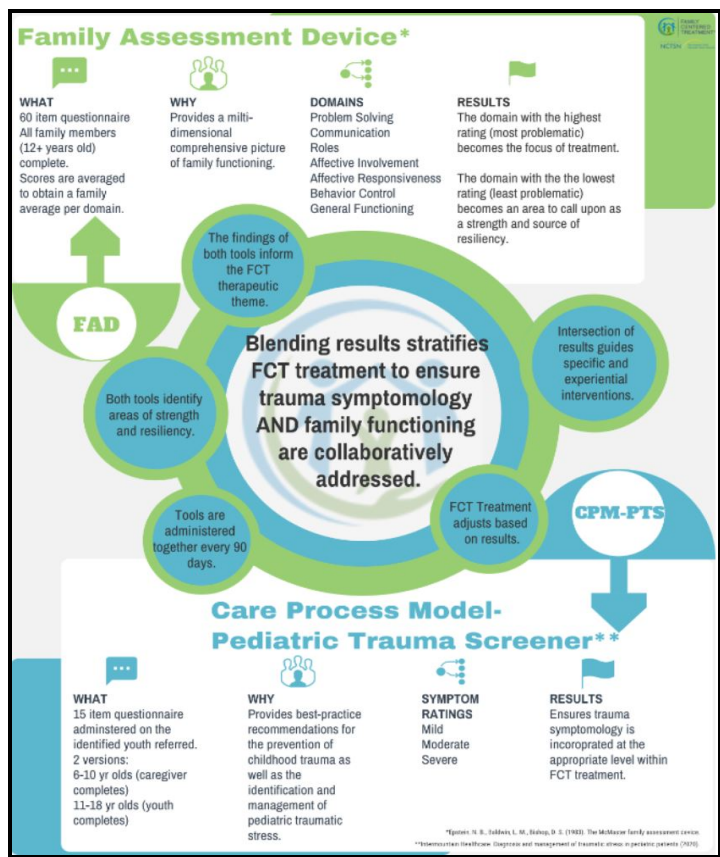
PIPS Highlights & Tips Partner Highlight:



The Family Centered Treatment Foundation (FCTF) owns an evidence-based family preservation treatment model called Family Centered Treatment (FCT), and licenses and supports its use in 32 agencies nationwide. FCTF is a Category II grantee within the National Child Traumatic Stress Network (NCTSN), which is how we came to partner.

The FCT model already had a screening tool looking specifically into how a family's dynamics impact their current levels of functioning, but according to their clinical director, Stephanie Glickman, LCSW, CCTP, "We knew we needed something more tangible and measurable to identify trauma symptomology given that most of our families are impacted by and working through their traumas. Through our partnership with NCTSN and shared participation in collaboratives, the FCT Foundation teamed up with the PIPS team after realizing they had the trauma screener we needed."

Through our recent partnership, FCTF has rolled out the CPM-PTS to their 32 agencies in 11 states, and trained over 300 providers. Since including the CPM-PTS in the FCT model, FCT Practitioners are uncovering trauma symptomology and suicidality sooner, intervening quicker, and are able to ensure more immediate supports and solutions for families. The image at left was created by FCTF to describe integration of the CPM-PTS within their model.



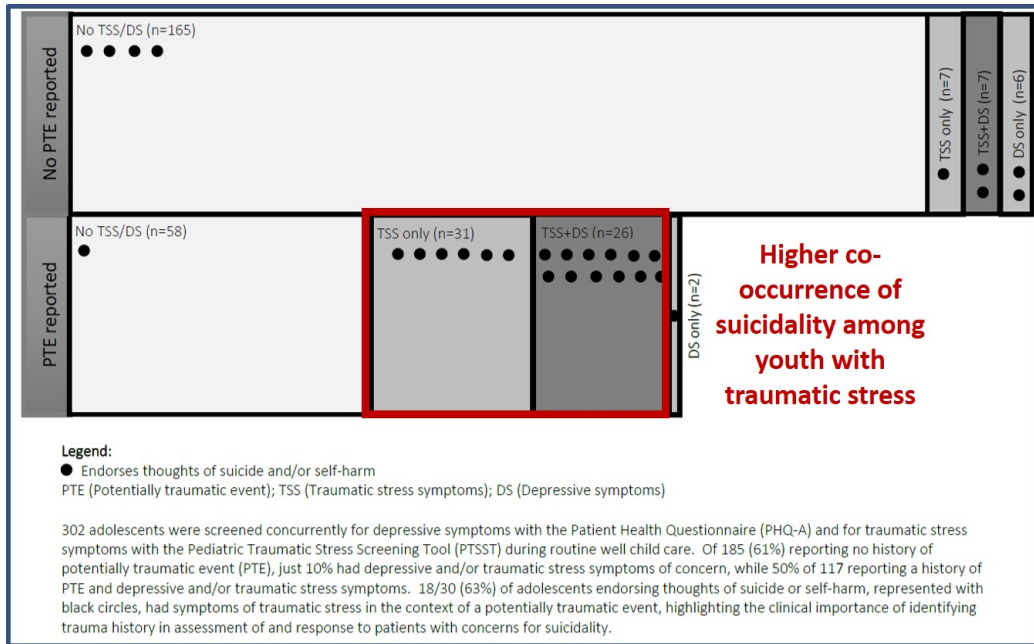
CPM-PTS Tip: Suicide Screening Matters

We know that asking questions and talking about suicide can bring up lots of feelings, and be scary and overwhelming. But our summary data of the CPM-PTS from both primary care and Children's Advocacy Center (CAC) settings show that suicide screening matters.



In CAC settings, 45% of adolescents, or about 1 in every 2, self-report having thought about suicide or harming themselves in some way in the last 2 weeks. 5%, or 1 in every 20, adolescents are assessed as high risk for suicide via the Columbia Suicide Severity Rating Scale (C-SSRS), meaning they indicate having suicidal intent, a plan, preparations, and/or a recent attempt.

In primary care settings among adolescents completing both the Patient Health Questionnaire for Adolescents (PHQ-A) and the Pediatric Traumatic Stress Screening Tool (PTSST), adolescents reporting potential trauma exposure (PTE) were 3.5 times more likely to report thoughts of suicide or self-harm (20/117, 17.1%) compared to those without this PTE history (9/185, 4.9%) ($p < 0.001$). See chart below.



With such high co-occurrence of suicidality and traumatic stress, as well as with its potential lethality, suicide screening and response among trauma-exposed youth matters in both CAC and primary care settings!

For additional suicide prevention training, follow this [link](#) for training videos in use of the Columbia Suicide Severity Rating Scale (C-SSRS), or email lindsay.shepard@hsc.utah.edu about additional PIPS consultation.

PIPS News

Two New Babies Join the PIPS Team

This fall, our Research Staff Assistant, Porcia Vaughn, MSIS, and our Program Manager, Lindsay Shepard, PhD, LCSW, were briefly on maternity leave. Both had healthy baby boys!

Meet babies Xander and Harry, our newest PIPS team members.

